

fluenza. The general opinion of those best qualified to judge is that vaccines and serums are of little or no use and that some of them may even be dangerous.

A committee which examined the action of various lactic ferments has come to the conclusion that while fermented milk is useful in some cases, that it is probably impossible to plant these bacillae in the intestines when they are taken in the form of tablets or suspended in water. Bacteriologists and scientists on the Committee were much more positive in this matter than the clinicians. It must be stated that many clinicians in hospital and general practice insist that the tablets or suspension are frequently efficacious.

Antimeristen (Schmidt) is apparently the first German product to be extensively advertised to the physician since the armistice. Several years ago the Council reported that the claims made for this were unwarranted and there seems no reason for changing this opinion. We shall probably again soon be flooded with German products and German literature and it is to be hoped that American physicians will be more discriminating than many have been in the past.

Luminal is a phenyl barbitol or veronal which seems to be useful in some nervous affections. The dose actually found safe in practice is 1 to 2 grains once or twice a day. Much of the literature on this article states that the dose is from 5 to 10 grains. This seems to be a dangerous dose as several cases have been reported in San Francisco and vicinity where 5 or 6 grains of luminal put the patient to sleep for 24 hours or more. This may be due to idiosyncrasy, but physicians should be careful to test their patients before ordering more than 1 to 2 grains as a dose.

Clinical Department

CASE HISTORIES FROM THE CHILDREN'S DEPARTMENT, UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL AND HOSPITALS.

Case No. 3. October 13, 1915. Female, American. Age 8 years. No. 10094. D. E.

Complaint: "Pain in stomach."

Family History: Father, four brothers, and three sisters living and well. Mother suffers from chronic chorea. Otherwise family history entirely negative.

Past History: Normal birth and development. Pertussis at the age of 3 months. Mumps at the age of 3 years, and pneumonia at the age of 2½ years. Otherwise the past history, except that directly referable to the present condition, is negative.

Present Illness: The child was in excellent health until approximately 1 year before entry (at the age of 5 years) when she was suddenly taken ill with acutely reddened, tender swellings of the knees, ankles, wrists and elbows. She was confined to bed for one month, and then apparently entirely recovered, except for very slight choreiform movement which persisted for a short period. One month before entry, she suffered another similar attack, which again confined her to bed. Two days before entry severe generalized, inconstant abdominal pains became a symptom. There was no hemoptysis or epistaxis. There was very slight, if any dyspnoea, although careful questioning elicited the fact that ever since her first attack, she had been accustomed to sleeping with at least two pillows elevating her head.

At entry the temperature was 38°, pulse 140, respirations 28.

Physical Examination: A well developed and nourished child, anaemic, slightly cyanotic, show-

ing moderate dyspnoea which becomes marked when the head is lowered. The skin shows a few petechial hemorrhages over the chest and abdomen.

Head, Eyes, Eye Muscles, Ears: Negative. There is a sero-sanguinous discharge from the right nostril. Buccal mucosa cyanotic.

Teeth: Very badly carious.

Tonsils: Much enlarged and cryptic. Moderate general cervical adenopathy.

Chest: Slightly prominent in region of lower sternum, somewhat more marked on the left.

Lungs: Negative.

Heart: Apex impulse not seen but felt 7 cm. to the left, from the mid-line in the 5th space. Beat is diffuse and not definitely localized. No thrill. Dulness extends from the mid-line to the left 9 cm. in the 6th space, 11 cm. in the 5th, 11 cm. in the 4th, 4¾ cm. in the 3rd. To the right, the dulness extends 3¾ cm. in the 2nd space, and 7 cm. in the 4th. The cardio-hepatic angle is obtuse. The sounds show a marked sinus arrhythmia but are of fair quality. A₂=P₂. They cannot be heard to the right of the sternum; best heard 1 cm. outside the nipple line in the left fifth space. Blowing systolic murmur heard best at the apex transmitted to axilla and back. "To-and-fro" pericardial friction rub heard at the base, fading toward apex and axilla, synchronous with systole and diastole. Radials equal, good volume.

Abdomen: Negative except for palpable nontender liver edge 3 cm. below costal border.

The remainder of the examination was negative.

Laboratory Examinations: Von Pirquet, Wassermann in blood serum, Blood Culture, and Culture from pericardial fluid were all negative.

Blood Count: Hb. 70%, R. B. C. 4,950,000, W. B. C. 17,750. Differential: Polys 80%, Lympho 10%, Large Mono 3%.

Urine: Positive for acetone and diacetic acid. Otherwise negative.

Throat Culture: All types of cocci. No hemolytic streptococci.

X-Ray findings: "Large Pericardial Effusion."

Pericardial Puncture: Needle inserted 4 cm. from the right sternal border in the 5th space. 10 cc. of sero-sanguinous material were withdrawn for diagnosis.

Diagnosis: Rheumatic endocarditis and Pericarditis with effusion.

Discussion: During the first 48 hours several syncopal attacks occurred, but the orthopnea was so easily relieved by the sitting posture that aspiration of the pericardial sac was not deemed necessary other than for diagnostic purposes, culture, etc. The effusion, too, began to be rapidly absorbed—within three days the area of dullness was appreciably less, and the heart shadow had lessened in size in the radiograph. Her temperature fluctuated in the neighborhood of 39° for three days and then dropped to normal. The pulse, however, showed wide variations for a month, then becoming much steadier. As the fluid was absorbed the endocardial signs became much more distinct, while, after a period of three months and extra-cardial (pleuro-pericardial) systolic murmur became distinctly audible, especially at the apex. (The occurrence of pleuro-pericarditis is unquestionably very frequent, in fact usual in these cases and there is great probability that many of the signs formerly ascribed entirely to adhesive pericarditis, between the visceral and parietal layers are in reality due to this condition.) At no time was a Broadbent's sign demonstrable, however. The child remained in the hospital for a period of six months, confined to bed entirely until the last three weeks of residence when she was allowed up for increasing lengths of time each day and also given graded exercises destined to

determine her cardiac capacity for work. During residence her teeth were placed in a healthy condition and one month after entry an adenotonsillectomy was performed with no ill toward effects. She suffered several attacks of acute coryza but at no time was there a reinfection of the cardia apparently. Three months after her entry her electro-cardiogram was entirely normal, and at the time of discharge, the examinations of the heart showed simply the presence of a chronic mitral regurgitation and the above mentioned pleuro-pericardial adhesions of slight degree. The pulse reaction to exercise and excitement was slight, the heart had hypertrophied but slightly, was fully compensated, and the radiograph was normal.

Medicinally, during the acute stage, aspirin was administered in 5 gr. doses every four hours. The use of the salicylates in rheumatic infections is variously regarded by different observers, many feeling that once the infection has taken place, little if any good is accomplished by their administration, and also that they are harmful from the depressant action on the myocardium. Others attribute this depression to the actual toxic influence of the infection, and therefore prescribe the drug in full doses during at least the period of greatest activity which was the plan followed in this case.

Tincture of Digitalis in tonic doses (m. III tid) was given after the first month continuously.

Pericardial puncture should be resorted to where pressure signs and symptoms are evident. Otherwise from the therapeutic standpoint it is not necessary. Opening and draining of the pericardial sac is a surgical procedure to be considered in the frankly purulent forms with many pressure signs and much toxicity.

Case No. 2 of this series demonstrates, with the present one, two very similar pictures, clinically, at the outset, but with entirely different etiology, course and outcome. Pericarditis is practically always secondary—a blood infection or one by direct extension. The former is exemplified in these two cases, the one being septicemic (staphylococcic) secondary to an abscess, with sero-purulent exudate, violent toxicity, with pyemic tendencies and rapid death; the other septicemic (rheumatic, probably streptococcic) secondary to an attack of acute rheumatic fever, with less toxicity, sero-sanguinous exudate which was rapidly absorbed and ultimate recovery.

The rheumatic form is probably more common, and from five to twenty-five years rheumatism is especially prone to cause pericarditis. Endocarditis is always present as is myocarditis. Upon the latter, to a very large extent, depends the course of the disease. The ultimate outcome also, in case of recovery, depends upon the extent of this myocardial damage, but also upon the amount of adhesive pericarditis which has resulted—this varies from obliteration of the pericardial cavity, with its interference in the cardiac action, to small bands or excrescences on the pericardium which cause little if any trouble.

The symptomatology is varied, but the most of the symptoms and signs are demonstrated in these two cases. Many of the attacks of pericarditis occurring in the course of other diseases, e. g., pneumonia, are undoubtedly missed entirely.

The prognosis varies with the severity of the infection and its type, as is demonstrated by the cases submitted. It is much worse in the sero-purulent forms than in the sero-fibrinous, the latter being typical of the rheumatic type of infection.

Balfour says, "Pericarditis, like other acute inflammations occurring in an otherwise healthy individual, may be expected to run a favorable course if not unduly treated."

State Board of Medical Examiners

COLLECTED CLIPPINGS ON MEDICAL LAW ENFORCEMENT

Lila Atherton, nurse, Los Angeles, arrested Jan. 21, 1920, by Sp. Agt. O'Connell, charged with the murder of Elsie Allen who died in the San Antonio Hospital, Uplands, from an illegal operation, alleged to have been committed by Mrs. Atherton. L. A. Examiner, 1/2/20.

Special Agt. Castellaw reported criminal abortion charge pending against above in Superior Court, L. A., on Jan. 1, 1918.

John Lafayette Berry, whose license to practice in California was revoked by the Board of Medical Examiners at the Oct. 1919 meeting, has been granted a writ of review by Superior Judge Cabannis of S. F. who will pass on the right of the Board to revoke the license.

S. F. Examiner, 12/27/19.

The Christian League of Healing and Helpful Service was organized in Los Angeles Jan. 13, 1920, which is expected to show to the faithful and faithless alike that "the prayer of faith shall save the sick."

L. A. Examiner, 1/11/20.

Chiropractors of Alameda County incorporate "to advance the science of chiropractic and to acquire the cohesive forces necessary to establish proper professional recognition." (None of the six directors are licensed to practice in the State of California). Oakland Tribune, 1/9/20.

The preliminary hearing of A. P. Francis of Oroville, charged with violation of the medical act was postponed to February 3rd, the defendant arguing the matter was within the jurisdiction of the Justice Court while attorney for the Board of Medical Examiners held the jurisdiction to lie in the Superior Court. Sacramento Bee, 1/23/20.

R. J. Frammer and Simon Muller, chiropractors recently arrested in San Francisco for violation of the medical act were held to answer in the Superior Court by Police Judge Morris Oppenheim.

An application of Dr. Thos. F. Glass for a writ of Review, directing the Board of Medical Examiners to restore his license, revoked February 20, 1918, was denied in Judge Jackson's Court in Los Angeles, January 6, 1920. Dr. Glass advertised a tuberculosis treatment.

Los Angeles Express, 1/6/20.

H. O. Hanna, chiropractor, was acquitted of the charge of practicing without a license in Police Judge Mortimer Smith's court, Oakland, on January 22, 1920. After the verdict had been rendered three of the jurors stated they were convinced that the accused practiced without a license but they did not believe him guilty. Attorney George Gelder, former assemblyman, defended Hanna. San Francisco Examiner, 1/24/20.

"Dr." Ottoman Zar Adusht Hanish who in 1904 worked as a printer in Salt Lake under the name of Herr Otto Hanisch was recently arrested in Chicago after a search of a year or more and returned to Los Angeles to stand trial under indictment for revolting offenses against little girls.

Los Angeles Times, 12/31/19.

A. B. Hinchley and H. A. Brown, choropracors of Richmond, recently arrested and charged with violation of the medical act expect to make a test case as to the rights of chiropractors to practice.

Oakland Tribune, 1/21/20.

In 1916 the U. S. Supreme Court upheld the constitutionality of the California medical act, in an appeal filed by P. L. Crane, drugless practitioner of Los Angeles and argued before the Supreme Court, December 12, 1916.

"If sick and in trouble I will pray for you gratis. Unknown. Box 18015, Tribune," is an advertisement in the Oakland Tribune of January 22, 1920.

What pays for the cost of advertising if treatment by prayer is "gratis"?